BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: ANDREW H., Claimant, vs. VALLEY MOUNTAIN REGIONAL CENTER, Service Agency.	OAH No. 2010091015

DECISION

This matter was heard before Administrative Law Judge Susan H. Hollingshead, State of California, Office of Administrative Hearings (OAH), in Modesto, California, on May 19, 2011.

The Service Agency, Valley Mountain Regional Center (VMRC), was represented by Barbara Johnson, Psy.D, Clinical Psychologist and Hearing Designee.

Claimant was present and represented by his mother.

Oral and documentary evidence was received. At the conclusion of the hearing, the record was closed and the matter was submitted for decision.

ISSUES

Is claimant eligible for regional center services based on a qualifying condition of autism or mental retardation pursuant to Welfare and Institutions Code section 4512, subdivision (a), and California Code of Regulations, title 17, section 54000?[1]

[1] Unless otherwise indicated, all statutory references are to the California Welfare and Institutions Code.

FACTUAL FINDINGS

1. Claimant is an unconserved nineteen year old man who currently lives with his mother. He has natural and step siblings who do not live in the home. His parents divorced when claimant was approximately five years old and he remained with his father until, at age sixteen, he came to live with his mother. Claimant began receiving services from VMRC in 2008. He presented with mental health and adaptive functioning concerns but limited information was available at that time. It was also unclear whether he was an individual with an Autism Spectrum Disorder (ASD). Claimant was made provisionally eligible for VMRC services with a review scheduled in two years "to reassess for diagnostic clarity and to determine to what extent his adaptive deficits are secondary to psychiatric disturbance versus ASD." At the time of preliminary eligibility, the VMRC "diagnosis" was" PDD-NOS (Pervasive Developmental Disability Not Otherwise Specified) and Schizophrenia, Paranoid Type."

2. The VMRC Interdisciplinary Eligibility Review Team met on May, 19, 2010, for redetermination of claimant's eligibility. The team determined that, "based on available information, claimant is not eligible for regional center services as there is no evidence to suggest autism, CP (Cerebral Palsy), epilepsy, MR (Mental Retardation) or other condition similar to MR."

3. As a result of this determination, a Notice of Proposed Action (NOPA) was issued to claimant on July 13, 2010, notifying him that "An interdisciplinary team composed of VMRC's clinical psychologist, physician, and service coordinator reviewed medical, psychological, and educational records and found your child ineligible for VMRC services". The reason for the action was that claimant "does not have a substantially handicapping developmental disability."

4. On August 9, 2010, claimant filed a Fair Hearing Request, disputing his ineligibility for services stating, "[Claimant] is being denied services because VMRC is saying he is not autistic. [Claimant] was diagnosed at 5 being autistic and everyone who has ever treated [claimant] knows he's autistic, it doesn't go away."

5. An "informal hearing" was held on September 8, 2010, regarding claimant's eligibility for regional center services. In addition to claimant and his mother, the meeting was attended by VMRC Clinical Psychologist Dr. Barbara Johnson and Health Administrator Joanne Eversole. During the meeting, claimant's mother "offered to provide new information to the regional center from [claimant's] teachers, counselors and psychiatrist." It was then "agreed to postpone the hearing for two months in order to allow time to collect and present the information to the regional center."

6. The informal hearing reconvened on November 17, 2010. By letter to claimant's mother on that date, VMRC concluded:

> VMRC eligibility team findings regarding [claimant's] ineligibility were obtained through a comprehensive examination of available medical, developmental, and educational documentary records. This process included review of previous test findings as well as a recent psychological evaluation performed by a VMRC vendored psychologist on April 22, 2010.
>
> [¶] . . . [¶]
>
> Available records based on a comprehensive cognitive assessment conducted by Dr. Herrera in 2007 suggest that [claimant's] cognitive functioning was within the average range of cognitive ability and thus not similar to an individual with mental retardation or a condition similar to mental retardation. Subsequent testing completed by Dr. Deprey on April 22, 2010 was commensurate with scores obtained by Dr. Herrera in 2007.
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> Turning to the question of possible autism, [claimant] has undergone a thorough psychological battery on two separate occasions which were based on California Best Practices with regard to assessment of autism spectrum disorders. It was following the initial evaluation conducted on April 25, 2008, that [claimant] was found **provisionally** eligible for regional center services with the recommendation of reassessment within two years given noted psychiatric history and presentation at time of assessment. As recommended, [claimant] was again re-examined by Dr Deprey on April 22, 2010. Results of the Autism Diagnostic Observation Schedule, review of collateral information and clinical observation did not suggest that [claimant] met the necessary criteria for an autism spectrum disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition-Text Revision. While [claimant's] adaptive functioning as measured by the Adaptive Behavior Assessment System-Second Edition was in the extremely low range of functioning in comparison to same age peers, these findings were however thought to be similar to an individual with significant mental health history such as that obtained during assessment and review of available record.
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> It was opined by Dr. Deprey that [claimant's] handicapping condition appears to be solely psychiatric in nature. This identified ongoing psychiatric condition, undoubtedly, presents

> substantial challenges for [claimant]. However, they also constitute exclusion criteria for VMRC eligibility as defined by California Welfare and Institutions Code[2] Title 17, Section 54000. Therefore, [claimant] is not eligible for VMRC services.

7. Pursuant to the Lanterman Act, Welfare and Institutions Code section 4500, et seq., regional centers accept responsibility for persons with developmental disabilities. Welfare and Institutions Code section 4512 defines developmental disability as follows:

> "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual….[T]his term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation [commonly known as the "fifth category"], but shall not include other handicapping conditions that are solely physical in nature.

8. California Code of Regulations, title 17, section 54000, further defines the term "developmental disability" as follows:

> (a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.
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> (b) The Development Disability shall:
>
> (1) Originate before age eighteen;
>
> (2) Be likely to continue indefinitely;
>
> (3) Constitute a substantial disability for the individual as defined in the article.
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> (c) Developmental Disability shall not include handicapping conditions that are:

[2] Should read California Code of Regulations.

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

9. Welfare and Institutions Code section 4512, subdivision (l), defines substantial disability as:

(l) The existence of significant functional limitation in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

(1) Self-care.
(2) Receptive and expressive language.
(3) Learning.
(4) Mobility.
(5) Self-direction.
(6) Capacity for independent living.
(7) Economic self-sufficiency.

10. Claimant first sought services from VMRC in October 2007 when he was sixteen years old. The VMRC Intake Assessment dated October 23, 2007, noted that claimant had recently been sent to live with his mother. [Claimant's mother] "is a single person and had not been prepared to receive [claimant]. Since his father sent him to live with her, she has been trying to adjust and make proper arrangements for him, such as trying to get him in school. This has been difficult as she does not have any of his school records and they have not been sent to the local school, as yet."

At that time, claimant's mother had very limited information regarding her son. She did relay that he had unremarkable developmental milestones as follows:

> Sat up: 6 months
> Crawled: 6 months
> Walked: 12 months
> Talked (single word): 9 months
> Talked (phrases): 16 months
> Toilet Trained: 2.5 years old

When asked when she first became concerned about her son's development, she stated "When [claimant] was attending a preschool he was pacing, involved in parallel play, making weird noises and did not like to interact with the other children."

11. The Intake Assessment stated that the reason for referral was, "Diagnosed with Autism at the age of 5 years old in Lawton, Oklahoma. [Claimant's mother] feels he may also be schizophrenia, as he exhibiting paranoid types of behavior [sic]." The VMRC Intake Coordinator noted that "all during the time this Intake Coordinator was at their home [claimant] was pacing from room to room." He then documented the following:

> OVERAL IMPRESSIONS
>
> It is very likely that [Claimant] was appropriately diagnosed within the Autism Spectrum. There is no real data to indicate schizophrenia. Because of the lack of communication between [claimants's] biological parents there is minimal information to review for impressions.
>
> INITIAL INTAKE RECOMMENDATIONS / PLANS
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> 1. Refer for psychological evaluation to help determine if eligible for VMRC services.
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> 2. Refer to ASD coordinator to screen for further ASD assessment.
>
> 3. Request medical/educational records to help determine if eligible for VMRC services.
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> 4. If found eligible for services:
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> A. Monitor educational/medical services to ensure appropriateness.
> B. Monitor living environment to ensure appropriateness.

12. VMRC referred claimant to Clinical Psychologist Arnold Herrera, Ph.D. "to assess his current level of intellectual and adaptive functioning as part of the eligibility process." The evaluation was conducted on November 20, 2007.

Dr. Herrera administered the Wechsler Intelligence Scale for Children - Fourth Edition (WISC-IV) and determined that claimant had a Full Scale IQ of 95 which "suggested average intelligence. This may be a slightly low estimate given uneven effort and engagement." He observed that "initially, [claimant] displayed a sullen disposition and acted like he was being forced to do something he did not want to participate in. Effort was poor and he would also make sarcastic comments. Anger seemed close to the surface. His speech had an atonal quality and he did not initiate any conversation. He seemed to have a rigid disposition. His engagement improved after I confronted him over having a bad attitude. This was followed by a consequent improvement in his performance level."

Dr. Herrera noted that claimant's "verbal and nonverbal skills were at the same basic [sic] but there was subtest scatter which was suggestive of learning and/or attentional problems, possibly due to distractibility, lack of effort or inconsistent engagement seen in ASD."

The Wide Range Achievement Test – Revision Three (WRAT-3) and the Vineland Adaptive Behavior Scales (VABS) were also administered. Claimant's "academic skills were mixed with Reading at the 7th grade level at a Standard Score of 85 while Arithmetic skills were 8th grade level at a Standard Score of 93. Adaptive abilities seemed borderline and in some cases just above the mildly delayed range (Communication SS: 75, Socialization SS: 71, Daily Living Skills SS: 78). He is clearly weakest in the socialization area."

13. After considering test results, interviews with claimant and his mother, mental status evaluation and behavioral observations, Dr. Herrera gave the following diagnostic Impression:[3]

Axis I: Rule [out] Autistic Spectrum Disorder (ASD).

[3] The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) is the current standard for diagnosis and classification It is a multiaxial system which involves five axes, each of which refers to a different domain of information as follows:

Axis I	Clinical Disorders
	Other Conditions That May Be a Focus of Clinical Attention
Axis II	Personality Disorders
	Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning

(312.30) Impulse Control Disorder NOS with Oppositional Defiant Features.

(315.31) Expressive Language Disorder by history.

Rule Out Depressive Disorder NOS with Anxious Features.

Axis II: (V71.09) No Diagnosis. Retains at least Average Intelligence

Axis III: None.

Dr. Herrera offered recommendations, including the following:

> A number of autistic features are present but he also struggles with anxiety and depression. Oppositional features are present as well. Consideration may need to be given to undergoing a complete evaluation to rule out ASD and/or establish a differential diagnosis. In the meantime, [claimant] would benefit from counseling to improve his behavioral disposition.

14. Lesley Deprey Ph.D. is a clinical psychologist who is employed by the UC Davis Health System as well as having a private practice in which she performs ASD evaluations. She has both Masters and Doctorate degrees in Counseling Psychology, has performed masters and graduate level research in the area of autism, and has an extensive background in the field. She is a trainer for the Autism Diagnostic Observation Schedule (ADOS) and ADOS Interview. She also has training in mental health disorders, notably serious emotional disturbance (SED), and has participated in clinical trails at a range of mental health facilities.

15. Claimant was referred to Dr. Deprey "to rule out an autism spectrum disorder. [Claimant] has been previously diagnosed with autism and clarification regarding his current presentation was requested." Dr. Deprey conducted an evaluation of claimant on April 25, 2008, following California Best Practices.[4]

16. As part of her evaluation, Dr. Deprey reviewed available records and considered previous diagnoses and psychological testing. She did not reassess claimant's intellectual functioning, as Dr. Herrera had conducted the WISC-IV within the previous six months. In addition to Dr. Herrera's evaluation she testified that intelligence testing had been completed through the school district on various occasions with a range of results. Her report included the following:

[4] California Best Practices refers to guidelines that provide a consistent and comprehensive base of information for screening, evaluation and assessment of persons with Autism Spectrum Disorder.

> Findings from the Leiter International Performance Scale-Revised completed in May 1997 resulted in a nonverbal IQ estimated at 98. According to clinical documents and IQ testing conducted in 2001, [claimant's] IQ fell in the 50s as assessed by the Wechsler Preschool and Primary Scales of Intelligence, 3rd Edition (WPPSI-III). Findings from the Stanford Binet-Fourth Edition (SB: IV) also completed in 2001 resulted in a test composite score of 67. Findings from the Vineland Adaptive Behavior Scales revealed an Adaptive Behavior Composite of 58. Diagnostic conclusions questioned the previous diagnosis of an autism spectrum disorder while describing significant intellectual impairments and concerns regarding oppositional defiant disorder.
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> In September 2007, [claimant] was evaluated by Dr. Domelsmith, Fort Hood Texas. Dr. Domelsmith's report indicated that [claimant] was initially diagnosed with pervasive developmental disorder at age 4; however his diagnosis has changed over time, with other diagnoses including high functioning autism and Asperger's disorder. [Claimant] also displays paranoia and excessive acting out behaviors at home and at school, including anger outbursts. As a result of [claimant's] refusal to cooperate with outpatient treatment, recommendations for inpatient emergency care were made at this time. Dr. Domelsmith's diagnostic conclusions were "autistic disorder and paranoid ideations" with concerns regarding a "brief psychotic disorder which may be a variant of post-traumatic stress disorder."

17. Dr. Deprey also considered claimant's extensive psychiatric history. At age fourteen, paranoid symptoms emerged. He had been hospitalized twice in the three months prior to this assessment reportedly as a result of increased agitation, delusional behavior and/or concerns regarding danger to others. She explained in part:

> Claimant has displayed anxious, socially withdrawn, and emotionally labile behavior; documentations of suspicious behavior and paranoid thinking include accusing others of watching him and also thinking listening devices are planted in the family home. Other psychotic behaviors include the belief that flies and other ordinary objects are miniature listening devices. [Claimant] has exhibited fantasies that private investigators are following him. He has also been observed talking to imaginary people. According to clinical documents, [claimant] refuses to believe that such events are false. . . Claimant also has a history of taking Zyprexa which was discontinued. He is currently prescribed Risperdal by Dr. Mora.

18. In addition to reviewing records, Dr Deprey considered behavioral observations noting that claimant "presented as a paranoid and anxious individual." "Clear evidence of psychosis was observed and reported during the assessment." She also utilized the Social Communication Questionnaire (SCQ), a parent questionnaire that is used as a screening instrument for ASD, and the Autism Diagnostic Observation Schedule: Module 4 (ADOS). The ADOS has been termed the "gold standard" for assessing and diagnosing autism and pervasive developmental disorder.

From the foregoing, Dr. Deprey made the following diagnostic formulation:

> Given claimant's history and his presentation during testing, a **DSM-IV-TR diagnosis of 299.80: Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS) seems most appropriate at this time.** [Claimant] has been previously diagnosed with autism; however given his history and clinical presentation during this assessment, a diagnosis of PDD-NOS seems to better conceptualize his current challenges. According to [claimant's] mother, concerns emerged during the preschool period. [Claimant] has evidenced significant delays in the development of social relationships. Limitations in the development of pretend play skills were reported. Sensory issues were also described. Inconsistent use of eye contact and difficulties appreciating subtle social cues were reported. Idiosyncratic language was observed during this assessment and conversation tended to be limited (although limitations in language usage appear to be better understood by another mental health condition –see next paragraph)….
>
> What seems most impairing at present is [claimant's] psychotic presentation. Given his history and current presentation, he clearly meets a **DSM-IV diagnosis of 295.30: Schizophrenia, Paranoid Type.**

19. On May 29, 2008, the VMRC Eligibility Review Team considered the available information and determined that claimant was provisionally eligible for services. Because claimant presented with PDD-NOS and delays in adaptive functioning as well as a diagnosis of schizophrenia with numerous symptoms, it was "unclear to what extent the severity of the psychiatric disturbance is contributing to the deficits in adaptive functioning." The team recommended coordination of psychiatric services with re-assessment when claimant's psychiatric symptoms are stable. The review noted "ASD and adaptive testing in 2 years for diagnostic clarity and to determine to what extent his adaptive deficits are secondary to psychiatric disturbance versus ASD. Re-determine eligibility at that time."

20. An Individual Program Plan (IPP) was developed for claimant on June 25, 2008. Objective three of the IPP stated, "[Claimant] will be re-referred through VMRC Clinical Department for a comprehensive diagnostic re-evaluation to confirm or revise his current Autism Spectrum Disorder (ASD) diagnosis and for subsequent determination of continued eligibility for Regional Center services eligibility at age 18 (two years)." The need for reassessment continued to be noted in claimant's subsequent IPPs.

21. On April 22, 2010, Dr. Deprey reevaluated claimant for diagnostic clarification as required by his IPP. She administered the Stanford Binet Intelligence Scales-Fifth Edition (SB-5) which determined that claimant's ABIQ (Abbreviated IQ Score) was estimated to fall in the low average range. These results were generally similar to those obtained by Dr. Herrera in 2007.

The Adaptive Behavior Assessment System-Second Edition (ABAS-II) is a norm-referenced, caregiver report questionnaire designed to assess an individuals adaptive functioning. Claimant's mother completed the ABAS-II and the overall results revealed that "when compared to same age peers, [claimant] is performing well below average in the extremely low range at the first percentile. . . Overall, improvements in adaptive functioning were reported; however the results of the ABAS-II revealed that considerable intervention in the area of everyday living skills remains warranted at this time."

The ADOS was re-administered and the examiner determined that "overall, the quality of [claimant's] interactions was similar to an individual with significant mental health issues; some traits of ASD were also observed."

22. As a result of this reassessment, Dr. Deprey made the following Diagnostic Formulation:

> **…it is this examiner's opinion that, although a few traits of ASD continue to be demonstrated, [claimant] no longer meets criteria for a diagnosis of Pervasive Developmental Disorder Not Otherwise** Specified **(PDD-NOS).**
>
> [¶]. . .[¶]
>
> What continues to be of primary concern is [claimant's] psychotic presentation. He continues to meet **DSM-IV-TR criteria for 295.30: Schizophrenia, Paranoid Type.**

23. The VMRC Eligibility Review Team concluded that, based on the available information at that time, claimant was not eligible for regional center services as there was no evidence that he met the criteria for a developmental disability required by section 4512.

24. Claimant's mother disagrees with this determination. She testified that more weight should be given to the opinions of those persons who are with claimant on a regular basis, rather than the assessments by examiners who have more limited contact. She specifically pointed to the determination of claimant's school district that he has continually qualified for special education services "because he is autistic."

25. A Modesto City Schools SELPA Individualized Education Program (IEP) dated December 13, 2007 indicated that claimant was eligible for special education services due to a primary disability of "ED" [Emotionally Disturbed] and a secondary disability of "AUT."[5] The basis for this determination was not given and subsequent IEPs have included the same eligibility determinations.

26. Darcy Tienken M.S.W., is a School Psychologist with Modesto City Schools. Claimant was referred to her "for a triennial evaluation to update his psycho-educational testing, measure progress, and determine his continued need and eligibility for special education services." Ms. Tienken noted that claimant began receiving special education support on November 23, 1999, and "has been eligible for services as a student with an 'Emotional Disturbance' and 'Autistic-Like'." The evaluation was conducted on February 26, 2010.

Ms. Tienken used several testing instruments including the Wechsler Abbreviated Scale of Intelligence (WASI) and the Test of Nonverbal Intelligence (TONI-3). On the WASI, [claimant] "obtained a Verbal IQ of 77 which is within the borderline range of intellectual ability. The subtests that make up the Performance IQ were not administered." The conclusion from the TONI-3 was that claimant's "abilities are in the very poor range when compared to children his age."

At the conclusion of her evaluation, Ms. Tienken concluded:

> [Claimant] continues to appear to qualify for special education services.
>
> [Claimant] meets the California Code of Regulations-Title 5, Article 3.1, Section 3030(h), Mentally Retardation [sic], which requires that [claimant] has significantly below average general intellectual functioning (TONI-3 quotient 64) existing concurrently with deficits in adaptive behavior (BASC 2 Adaptive Functioning at home was in the clinically significant range with a t-score of 28) and manifested during developmental period (delayed speech), which adversely affect a pupil's educational performance (KTEA scores are in the extremely low range).

[5] This term was defined in the Modesto City Schools Psycho-Educational Assessment Report as "Autistic-Like"

> [Claimant] also continues to qualify as a student with Autistic-Like Behavior. He has been medically diagnosed with an Autism Spectrum Disorder and/or Asperger's.

27. A previous School Psychological Evaluation was conducted in Texas by William Cofield, Psy.D. Dr. Cofield's report dated October 18, 2004 and addendum dated January 10, 2005, specifically addressed assessment for emotional disturbance and/or PDD-NOS.

Dr. Cofield noted a history of variable IQ scores that "have ranged from the 50's up to the 80's." It was "the general consensus of the individuals in the room that [claimant's] true intellectual ability is very likely higher than that reflected in the measurements."

The report also stated, "We also discussed the historical diagnosis of a pervasive developmental disorder. It is not apparent that [claimant] clearly meets the criteria for any specific pervasive developmental disorder. However, he does present with some features of PDD…"

"Additionally, we discussed the possibility of an emotional disturbance. The available information indicates that from the earliest ages [claimant] has had significant behavioral and relationship problems. These appear to be worsening over the past few months. While many of his behavioral difficulties appear to be willful, it is also observed that his interpersonal skills are remarkably impaired. He also displays behavior which is contextually inappropriate, unpredictable, and maladaptive. He has been aggressive and been described even as "violent."

The report makes the following conclusions:

> Based on the newly available multidisciplinary information, I would revise the previous recommendations as follows:
>
> 1. We would recommend that while [claimant] does not present with characteristics of an autistic disorder, he does continue to present with some autism spectrum disorders, perhaps best diagnosed as PDD-NOS.
>
> 2. We would recommend to the ARD Committee that [claimant] presents with the characteristics of an emotional disturbance as defined in TEA guidelines based on 1) inappropriate behavior under normal circumstances and 2) an inability to build or maintain interpersonal relationships with peers and teachers.

28. Dr. Deprey testified that school psychologists follow rules governing education law to determine eligibility for special education services which are not the same as the requirements provided in the Lanterman Act for regional center eligibility. She also stated that the diagnostic impressions by some of the previous providers were not based on California Best Practices or defined pursuant to the DSM-IV-TR.

29. Two letters were provided by claimant's psychiatrist, Bernard Mora, MD, addressing claimant's condition. The first, dated July 16, 2010, states:

> I have been asked to write this letter by [claimant's] mother. [Claimant] has been under my care for several years. His diagnosis is Asperger's Disorder, in the autism spectrum.

A second letter, dated November 16, 2010, included the following:

> This letter was written at the request of [claimant] and his mother. Claimant has been under my care since April, 2008; I have most recently seen him on November 9th, 2010. I have also reviewed the psychological evaluation of April, 2010.
>
> I disagree with the diagnostic 'revisions' proposed by the psychological evaluation. I continue to have [claimant] diagnosed as Asperger's syndrome, and Psychotic Disorder NOS. While [claimant] has made gains in his social functioning, these are not to the point where he no longer meets criteria for a Pervasive Developmental Disorder.
>
> The psychological evaluation proposed a diagnosis of Schizophrenia. I have not diagnosed him with that; at this time he is not paranoid and he has not had nay aggressive behaviors for at least a year. His thought processes are better characterized as "perseverative" (on the autism spectrum) rather that "psychotic" with poor reality testing.
>
> I believe that the support services that [claimant] may need from VMRC are appropriate and should not be denied based on the proposed diagnostic revisions above. I also understand that we may [be] talking about "two sides of the same coin" here, yet I believe that [claimant] remains eligible for VMRC services, his recent psychological evaluation notwithstanding.

Dr. Mora did not state the basis for his belief that claimant remains eligible for VMRC services, nor was any assessment information provided to support his stated diagnoses.

30. Claimant's mother presented as a caring and concerned parent whose desire is for her son to live a "normal, successful and productive life." She testified that claimant is "doing absolutely wonderful regarding the paranoia." "He is on medication (Risperdal) and there are no issues with that…I am not asking for help with that." She stated that claimant's medication has been reduced twice and is just being used now to help him with "sleeping and relaxing." She opined that because his mental health concerns are stabilized he "does not fit in with Mental Health because this is not his issue." She testified that she wants services for her

son that VMRC can provide and there is "no other help out there for him." She concluded that "if there is anybody who's autistic, it's my son."

LEGAL CONCLUSIONS

1. Eligibility for regional center services is limited to those persons meeting the eligibility criteria for one of the five categories of developmental disabilities set forth in section 4512 as follows:

> "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual….[T]his term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation [commonly known as the "fifth category"], but shall not include other handicapping conditions that consist solely physical in nature.

Handicapping conditions that consist solely of psychiatric disorders, learning disabilities or physical conditions do not qualify as developmental disabilities under the Lanterman Act.

Eligibility Based on Autism

2. "Autism" as set forth in section 4512 is defined in the DSM-IV-TR. The text addresses autism in the section "Pervasive Developmental Disorders." There are five "Pervasive Developmental Disorders" identified in the DSM-IV-TR: Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS).

DSM-IV-TR section 299.00, Autistic Disorder, states:

> The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests . . . The impairment in reciprocal social interaction is gross and sustained. . .The impairment in communication is also marked and sustained and affects both verbal and nonverbal skills.

To diagnose Autistic Disorder, it must be determined that an individual has at least two qualitative impairments in social interaction; at least one qualitative impairment in communication; and at least one restricted repetitive and stereotyped pattern of behavior,

interests, or activities. One must have a combined minimum of six items from these three categories. In addition, delays or abnormal functioning in at least one of the following areas, with onset prior to age three, is required: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.

This section also notes that "Autistic Disorder must be differentiated from other Pervasive Developmental Disorders." And, "Asperger's Disorder is not diagnosed if criteria are met for Autistic Disorder."

3. Asperger's Disorder is addressed in DSM-IV-TR section 299.80 which states:

> The essential features of Asperger's Disorder are severe and sustained impairment in social interaction (Criterion A) and the development of restricted, repetitive patterns of behavior, interests and activities (Criterion B). The disturbance must cause clinically significant impairment in social, occupational, or other important areas of functioning (Criterion C). In contrast to Autistic Disorder, there are no clinically significant delays or deviance in language acquisition (e.g., single non-echoed words are used communicatively by age 2 years, and spontaneous communication phrases are used by age 3 years) (Criterion D), although more subtle aspects of social communication (e.g., typical give-and-take in conversation) may be affected. In addition, during the first 3 years of life, there are no clinically significant delays in cognitive development as manifested by expressing normal curiosity about the environment or in the acquisition of age-appropriate learning skills and adaptive behaviors (other than in social interaction) (Criterion E). Finally, the criteria are not met for another specific Pervasive Developmental Disorder or for Schizophrenia (Criterion F). This condition is also termed Asperger's syndrome."
>
> This section also states that "Asperger's Disorder must be distinguished from the other Pervasive Developmental Disorders, all of which are characterized by problems in social interaction. It differs from Autistic Disorder in several ways." . . . "By definition the diagnosis is not given if the criteria are met for any other specific Pervasive Developmental Disorder or for Schizophrenia (although the diagnoses of Asperger's Disorder and Schizophrenia may coexist if the onset of the Asperger's Disorder clearly precedes the onset of Schizophrenia) (Criterion F).

Diagnostic criteria for 299.80 Asperger's Disorder are specified in the text.

4. DSM-IV-TR 299.80 states that Pervasive Developmental Disorder Not Otherwise Specified is the category that should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interest, and activities, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder.

5. The DSM-IV-TR clearly demonstrates that Autism, Asperger's Disorder and PDD-NOS are distinct and mutually exclusive diagnoses. It was undisputed that claimant has, at various times, been diagnosed with PDD-NOS, Asperger's and "Autistic-Like" symptoms. Welfare and Institutions Code section 4512 recognizes autism as a qualifying developmental disability but does not recognize the other noted conditions.

Eligibility Based on Mental Retardation

The diagnostic criteria for "Mental Retardation" as set forth in section 4512 is defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) to require:

> A. Significantly subaverage intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test…
>
> B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her age by his or her culture group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
>
> C. The onset is before 18 years.

While claimant's intelligence testing history shows score discrepancies, he did attain results that were higher than those required for a diagnosis of mental retardation. The testimony was persuasive that lower test results could be the result of other factors including psychiatric condition, effort and attention.

6. Claimant's presentation is complex and the evidence was persuasive that he has substantial limitations. There was a demonstrated presence of a psychiatric condition evidenced since childhood complicated by a variety of other conditions. His mother persuasively contends that he is impaired by those limitations and would benefit from regional center services. However, regional center services are limited to those individuals meeting the stated eligibility criteria. The evidence presented did not prove that claimant's current impairments resulted

from a qualifying condition which originated and constituted a substantial disability before the age of eighteen.

7. Claimant bears the burden of establishing that he meets the criteria for regional center eligibility.[6] Claimant has not met that burden. Evidence presented did not support a finding of autism or mental retardation. In addition, there was no evidence presented that claimant has cerebral palsy, epilepsy, or a disabling condition found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation pursuant to section 4512. Accordingly, he does not have a developmental disability as defined by the Lanterman Act and is not eligible for services through VMRC.

ORDER

Claimant's appeal from the Valley Mountain Regional Center's denial of services is denied.

DATED: June 1, 2011

_____
SUSAN H. HOLLINGSHEAD
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision in this matter. Each party is bound by this decision. An appeal from the decision must be made to a court of competent jurisdiction within 90 days of receipt of the decision. (Welf. & Inst. Code, § 4712.5, subd. (a).)

[6] California Evidence Code section 500 states that "[e]xcept as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting."